Stephanie M. Marko, M.D., LLC
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Authorization for Release and Exchange of Information with Stephanie Marko, MD

I, _____ (DOB_____), hereby authorize the release and exchange of information specified below between **Stephanie Marko, M.D**. and:

Name(s): _____

Address: _____

_____

Phone: _____

Fax: _____

Purpose of the disclosure authorized (as specific as possible):

☐ Coordination of Care ☐ Referral ☐ Payment ☐ Utilization Management ☐ Other

Data may be released in written, verbal, or electronic form and may include copies of the following information:

(Please check all applicable information, enter NA if not requested)

__	Psychiatric Evaluation	__	Psychological/Educational Testing
__	HIV/AIDS History and Tx	__	Alcohol or Substance Abuse History and Tx
__	General Progress in Treatment	__	Medication History/Physician Orders
__	Service Plan/PCP	__	Labs and Special Tests as Indicated
__	Discharge Summary	__	Other: _____

This doctrine of authorization of release has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is truly voluntary. This consent is subject to revocation by written instructions of the undersigned at any time. Further, I understand that this consent shall expire and must, if needed, be re-obtained twelve (12) months from the date below.

_____ _____

Client Name (Print) Provider Signature

_____ _____

Client Signature Date

CONFIDENTIAL

Anyone receiving this information must also treat this medical information as confidential and needs to follow HIPAA and CFR42 guidelines.